BRIGHTON TOWNE DENTAL
2101 Lac De Ville Boulevard, Rochester NY 14618
Phone (585) 271-6300 Fax (585) 442-1949

Patient Full Name: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____

Sex: M / F Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Cell Phone (_____)_____

Email _____

Whom may we thank for referring you? _____

Emergency Contact:_____ Relationship: _____

Phone numbers: _____

Who is responsible for this account: _____

Date of Birth _____ SS#_____

Address: _____

Dental Insurance Company _____

Subscriber/Policy Holder _____

Subscriber Social Security Number _____

Subscriber Date of Birth_____

Employer_____

ID#_____ Group# _____

Is the patient covered by additional insurance? Yes / No
If yes, list information on back of this page in the order above

Assignment and Release

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand **that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance**, and that **I will** be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. **I agree to pay all estimated out of pocket expenses on the day of service.**

I have read and understand the above. Any questions I had about this form have been answered and I understand the answer. I attest to the accuracy of the information contained on this page.

Signature of Patient/Guardian/Personal Rep

_____

Printed Name of Patient/Guardian/ Personal Rep

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION/HIPAA

I, _____authorize the release of my (or my dependent's _____) confidential protected dental information, as described in the AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions (list on the back of this sheet if necessary). The information that is used and/or disclosed pursuant to this authorization may be re disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information. This information may include my dental treatment, condition or information contained within my dental chart and history for purposes of my health care. I also give permission for messages to be left on my voicemail, text and/or e-mail of listed numbers. I also confirm that I have been offered a copy of the office notice of privacy. **The following person has been granted permission by me to speak and or receive information on me or my dependents behalf regarding my dental treatment, diagnosis, scheduling, and billing. Name _____**

Signature of Patient/Guardian _____

Date_____

Today's Date _____
Patient Name_____

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Date of Birth_____

Are you now under the care of a physician? Yes / No
If yes, Physicians name _____
If so, for what condition?_____

Primary Physician's Name _____phone _____
Specialist's Physician's Name _____phone_____
Any serious illness, operation or hospitalization in the past 5 Years? Yes/No
If yes, what for?

DENTAL HISTORY:

Former Dentist _____ Phone _____
Date of last dental visit:
Circle Yes/No to indicate if you have had any of the following:

HEALTH HISTORY:

Sores/Blisters on lips or in mouth:	Yes/No
Dry Mouth	Yes/No
Ear Pain	Yes/No
Previous Orthodontic Treatment:	Yes/No
Jaw Pain	Yes/No
Clenching/ Grinding	Yes/No
Previous Periodontal Treatment	Yes/No
Jaw Clicking/popping	Yes/No
Use smokeless Tobacco	Yes/No
Use Cigars/Pipe/Cigarettes	Yes/No
Abnormal Bleeding	Yes/No
Arthritis/Rheumatism	Yes/No
Aspirin Therapy	Yes/No
Asthma or other lung disease	Yes/No
Alcohol Abuse	Yes/No
Alzheimer's/Dementia	Yes/No
Bleeding disorders	Yes/No
Cancer (Type _____)	Yes/No
Chemical Dependency	Yes/No
Diabetic (Type _____)	Yes/No
Epilepsy/Seizures, Convulsions	Yes/No
Fainting/Dizziness	Yes/No
Frequent Headaches	Yes/No
HIV+ or AIDS	Yes/No
Hepatitis A B C (circle one)	Yes/No
High Blood Pressure	Yes/No
Low Blood Pressure	Yes/No
Joint Replacements	Yes/No
Pins, plates, rods or screws	Yes/No
Kidney Problems	Yes/No
Liver Disease	Yes/No
Psychiatric Problems (List _____)	Yes/No
Radiation Treatment/Therapy	Yes/No
STD's	Yes/No
Sinus Trouble	Yes/No
Thyroid Disease	Yes/No
Congenital Heart Disease	Yes/No
Cardiovascular (heart attack, surgery, Angina…)	Yes/No
Artificial Heart Valve, Pacemaker or stents	Yes/No
Stroke	Yes/No

MEDICATIONS:
Are you taking any medicine(s), diet pills, non-prescription Vitamins and or supplements, homeopathic or natural Remedies? List here _____
_____
_____
(Please attach a separate list of medications if needed)

ALLERGIES:
Are you allergic to or had a reaction to:

Local Anesthetics	Yes / No
Barbiturates (sleeping pills)	Yes / No
Iodine	Yes / No
Latex	Yes / No
Aspirin	Yes / No
Codeine	Yes / No
Erythromycin	Yes / No
Penicillin family	Yes / No
Tetracycline	Yes / No
Sulfa Drugs	Yes / No
Metals	Yes / No

Other please list _____

FOR WOMAN ONLY:

Are you pregnant or is there any chance you MAY be pregnant	Yes / No
Are you Nursing	Yes / No
Are you using Oral Contraceptives	Yes / No

Please list any other health related conditions, diseases Or health problems that you think we should be aware of

I understand the importance of a **truthful and complete health history** to assist my dentist in providing the best care possible and I have filled this out to the best of My ability.

Signature of Patient or Guardian _____

Office Use Only: Assistant's Initials _____
Front Desk Initials _____

Appointment Confirmations:

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Appointment Cancellation Policy:

We understand that situations arise in which you can't make your scheduled appointment and we ask that you provide us with at least a 48 business hour notice to cancel or change the appointment. By doing so, we can offer your time to another patient who is waiting to receive services. The lack of adequate notice is considered a "late cancel", as we are unable to use your appointment slot for another patient. No shows and cancellations with less than the required notice may be subject to a **$35** cancellation fee. Patients who do not show up or give inadequate notice two (2) or more times may also be dismissed from the practice and will be denied any future appointments. Cancellation fees are the sole responsibility of the patient and must be paid in full before the next appointment. We understand that special unavoidable circumstances may cause you to miss your appointment or give inadequate notice. Cancellation fees in this instance **may** be waived at the discretion of management. Our practice firmly believes that a positive provider/patient relationship is based upon understanding, good communication and mutual respect. If you have questions about our cancellation policy, please ask our front desk staff.

ADDITIONAL BILLING FEE:

If estimated charges are not collected on day of service please be aware there will be a billing fee of **$12.00**.

RETURNED CHECK FEE:

If your check for payment is returned to us for insufficient funds then you will receive a charge of **$50.00**.

Please sign that you have read, understand and agree to these office policies.

Patient Name_____

Authorized Signature_____

Date _____

*Services will not be provided if there is an outstanding family balance of $50.00 or more.

Every appointment requires a confirmation that you will be at your appointment. If we do not obtain a confirmation from you then you risk being pulled from our schedule. Also please be aware that scheduled appointment times may shift on occasion to accommodate other changes in our schedule. You may be notified electronically or by direct contact from the office.